UNPUBLISHED

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
CENTRAL DIVISION

JO A. HENRICHS,

Plaintiff,

vs.

JO ANNE B. BARNHART,
Commissioner of Social Security,

Defendant.

No. C02-3086-PAZ

MEMORANDUM OPINION AND ORDER

TABLE OF CONTENTS

I. INTRODUCTION

The plaintiff Jo A. Henrichs ("Henrichs") appeals a decision by an administrative law judge ("ALJ") denying her application for Title II disability insurance ("DI") benefits. Henrichs argues the Record does not contain substantial evidence to support the ALJ's decision. Specifically, Henrichs argues the ALJ erred in substituting his opinion for that of the medical experts, improperly weighing the evidence, presenting an inaccurate hypothetical question to the Vocational Expert, arriving at a residual functional capacity assessment that is not supported by the evidence, and discounting her credibility. (*See* Doc. No. 13)

II. PROCEDURAL AND FACTUAL BACKGROUND

A. Procedural Background

On July 24, 2000, Henrichs protectively filed an application for DI benefits. (R. 81-83) She initially alleged a disability onset date of May 10, 1993 (R. 81), but subsequently amended her alleged onset date to June 1, 1999. (R. 41, 137) The application was denied initially on December 20, 2000 (R. 66, 68-71), and on reconsideration on April 30, 2001 (R. 67, 74-78). On May 16, 2001, Henrichs requested

a hearing (R. 79), and a hearing was held before ALJ Thomas Donahue on October 11, 2001, in Fort Dodge, Iowa. (R. 37-65) Henrichs was represented at the hearing by attorney Jeff Speicher. Henrichs testified at the hearing, as did Vocational Expert ("VE") Carma Mitchell.

On March 6, 2002, the ALJ ruled Henrichs was not entitled to benefits. (R. 10-23) On September 19, 2002, the Appeals Council denied Henrichs's request for review (R. 6-8), making the ALJ's decision the final decision of the Commissioner.

Henrichs filed a timely Complaint in this court on November 8, 2002, seeking judicial review of the ALJ's ruling. (Doc. No. 1) On December 10, 2002, upon the parties' consent to jurisdiction by the undersigned United States Magistrate Judge, Judge Donald E. O'Brien transferred the case to the undersigned. (Doc. No. 4). Henrichs filed a brief supporting her claim on July 3, 2003. (Doc. No. 13) The Commissioner filed a responsive brief on August 28, 2003. (Doc. No. 14). The matter is now fully submitted, and pursuant to 42 U.S.C. § 405(g), the court turns to a review of Henrichs's claim for benefits.

Preliminarily, the court notes that for purposes of her application for DI benefits, Henrichs must show she was disabled prior to her date last insured of June 30, 1999. *See Krogmeier v. Barnhart*, 294 F.3d 1019, 1022 (8th Cir. 2002); *Stephens v. Shalala*, 46 F.3d 37, 39 (8th Cir. 1995).

B. Factual Background

1. Introductory facts and Henrichs's daily activities

At the time of the hearing, Henrichs was 53 years old, and living with her husband in Pioneer, Iowa. She was 5'7" tall and weighed 185 pounds, which she explained was a significant gain since 1999. (R. 40) She had a driver's license, and stated she used to

drive somewhere almost daily but she had stopped driving much since the onset of vision problems. (R. 41)

Henrichs completed the twelfth grade in school and has not had any other formal or vocational-technical training. She worked from 1988 to 1993 as a warehouse person and assembly machinist at Iowa Hydraulics. When she worked in the warehouse, she would load and unload trucks, fill orders, and put materials away. The job required a lot of lifting, including castings weighing as little as twelve pounds and as much as 150 pounds. She and other employees had to transfer the castings from boxes, put them up on shelves, and move them to other locations. The work also required a lot of bending over and lifting above her head, and counting of small pieces. She quit the job in May 1993, when she was injured while lifting some heavy materials at work. (R. 42)

From 1993 to 1999, Henrichs helped her husband in a salvage business they own. She stated, "If there was heavy lifting and unloading trucks, I did that for a while until I couldn't do it anymore. And basically I'd clean the motors or take apart stuff. And that got to be where my hands wouldn't do that because of the wrenches and stuff." (R. 43) The amount of weight she might have to lift when helping her husband varied. When she first started helping him in 1992 or 1993, she lifted anywhere from five to thirty-five pounds frequently, and 75 to 100 pounds occasionally. (R. 61-62)

In 1995, Henrichs was diagnosed with degenerative disk disease in her low back. She had an MRI, and her doctor said her "disk was bulged," and advised her to use ice, medication, and rest. He said she should not lift. She stated her back problem limits her ability to lift, bend, and ride an exercise bike. Riding the exercise bike irritates her hips and lower back. Sitting and lifting her grandchildren make the pain worse. She is no longer able to get into the back of a truck to unload it. She stated she always exercised and can no longer do that. She uses ice for about twenty minutes every two hours to relieve

her low back pain . She is not able to sit in one position for very long, and stated she tapes television shows because she can only sit and watch TV for about half an hour at a time. (R. 43-45)

Henrichs stated she has arthritis in her neck, and while the muscle spasms in her back come and go, the pain in her neck is constant. Because of her neck pain, she is unable to sit and read, sew, play a game, or do crafts. If she over-exerts herself, she will have pain in her neck and up the back of her head for several days. She also cannot look down to sweep the floor, wash windows, do gardening, or transfer clothes from the washing machine to the dryer. She is able to fold clothes when they come out of the laundry, but she cannot bend down to transfer clothes from the washer to the dryer. Henrichs uses ice, and medications such as Ultram and Celebrex, for the pain. She saw a chiropractor, which helped for awhile, and she received cortisone injections that helped at first but quickly became ineffective. (R. 46-48)

Henrichs started having problems with double vision, especially when she was watching TV, or late in the day when she was tired. The problem was worse when she tried to sew, do crafts, or read. At first, the problem occurred every night, but by the time of the hearing, she stated it was happening all the time. (R. 48-49)

Henrichs stated her current diagnosis is multiple sclerosis. (R. 49) In 1997, she was diagnosed with arthritis in both of her thumbs. She had cortisone shots every three to six months. (R. 50) In June 1999, she began to have difficulty lifting pots and pans when she was cooking, and even smaller things. (R. 43) Her husband had to help her with cooking, such as lifting pans out of the oven. She had a limited ability to grasp, handle things, and manipulate items, and she lifted very little. She had been able to help her husband in the salvage business in the past, using small tools, but by 1999, she no longer was able to do that. She could not do housework or crafts that required using her

thumbs. (R. 51-52) She had sharp pain that went up her arm, and it hurt even to "get in the car and turn the key over." (R. 50) When the cortisone shots quit working altogether, she had surgery on her hands. Surgery was performed on the first thumb in December 1999, and on the second thumb in October 2000. (R. 50)

In May 1999, she was diagnosed with a tear in her left ACL and a bilateral meniscus tear. She had intense pain in her knee for the first three weeks after the tear happened, and then she started walking on it again. She wore a brace for a couple of weeks, put ice on the area, took medication, and limited her walking. Her doctor talked about surgery, but Henrichs declined because she had other problems she considered to be worse. She still has knee pain from the condition. She stated her knee locks up on her. She avoids walking on ice at all, and she cannot sit or stand in one place for a long time without having pain. (R. 52-53)

In January 1999, Henrichs began experiencing intermittent shortness of breath. The problem came on gradually. She has always walked for exercise, and always walked the same route in her town. She stated it became more and more difficult for her to walk the same distance. At first, she thought it was the cold weather bothering her, but the condition continued to worsen. In addition, she would experience a rapid heartbeat and sharp pains in her chest. The condition made her feel very fatigued and drained. After a heart monitor test, her doctor told her she had an erratic heartbeat and put her on some medication. He said the condition was not life-threatening, but it could cause her problems if left untreated. (R. 53-55; *see* R. 43-44)

A typical day for Henrichs, in 1999, started with getting up in the morning and then going into town with her husband to pick up a load of salvage materials. She might walk up to the grain elevator and talk to people or do something to keep herself busy. She could walk about two miles in twenty to thirty minutes. She sometimes stopped and rested

during her walk, and she rested when she got back home. If she did not get to walk in the morning, she usually was not able to take a walk by afternoon. When she started having problems with shortness of breath, she sometimes could not walk two miles because she "would run out of steam." (R. 55-56, 58-59)

When Henrichs helped her husband in his business or did housework, she could work for thirty minutes to an hour before she needed a break. If her husband really needed help and she worked all day, the next day she would feel "drained out," and it would take her a couple of days to recuperate. According to Henrichs, sometimes even riding into town with her husband would be too much for her. (R. 56)

Also in 1999, Henrichs began experiencing dizziness when she bent over, turned, arose from a chair quickly, or made any sudden moves. She had always had a big flower and vegetable garden, but beginning in 1999, she no longer was able to plant a garden. She no longer mowed the lawn, and beginning in December 1999, she no longer made Christmas candies because she could not tolerate the stirring and lifting the pans. (R. 56-57) Henrichs stated that in 1999, she would not have been able to stand in one place and do a job for six to eight hours because of back pain, leg pain, and fatigue. (R. 57-58)

Since 1999, Henrichs's condition has "just gone downhill." (R. 58) Until she was diagnosed with MS, she thought she was losing her mind. She was following all her doctors' orders and seeking treatment regularly but was not improving, and until the MS diagnosis, no one was able to give her a clear explanation for her symptoms. (R. 58)

2. Henrichs's medical history

The court has prepared a detailed chronology of Henrichs's relevant medical history that is attached as Appendix A to this opinion. Henrichs alleges she is disabled due to pain in her back, neck, hips, and hands; arthritis; migraine headaches; and a neck injury. She

also has complained of gastrointestinal conditions, throat lesions, obesity, chronic sinusitis, and a torn ACL with lateral meniscus tear of the left knee. (*See* R. 14, 96) The court will summarize the medical evidence relating to the most significant of Henrichs's medical problems.

a. Back pain; hip and leg pain

Henrichs began complaining of pain in her left hip and leg in October 1995. She stated her symptoms worsened after she rode more than six miles in a car. Her treating physician, C. Mark Race, M.D., diagnosed her with trochanteric bursitis of the left hip and degenerative disc disease of the lumbosacral spine, with radiculopathy, and probable herniated disc at L5-S1. Henrichs cannot take nonsteroidal anti-inflammatories because they aggravate her asthma, so Dr. Race prescribed a Medrol Dosepak and Ultram. (R. 320-21) Henrichs's pain continued, and on December 15, 1995, she had X-rays of her lumbosacral spine and an MRI. Upon reviewing the MRI, the radiologist noted Henrichs's "L5-S1 disk space is virtually obliterated." (R. 139) The studies revealed degenerative changes involving the L2-3 to L5-S1 disks, more advanced at the L2-3 level and significantly advanced at L5-S1; and mild posterior disk herniation at L4-5, resulting in mild spinal stenosis and effacement of the anterior thecal sac. (*Id.*)

In February 1996, Dr. Race recommended lumbar epidural steroids for Henrichs's back pain, but the treatment was not performed at that time. (R. 319) By May 2, 1996, Henrichs reported her right hip pain had improved and her leg pain was gone. She reported ongoing difficulties with her back and some residual pain in her left buttock, but otherwise she was back to normal activities. Dr. Race recommended continued conservative management of her back pain. (R. 286) Henrichs was not seen again for complaints of back pain until April 1997. She reported Ultram and Lodine helped her pain, and

records indicate she was "doing quite well." (R. 283) She was trying to use proper body mechanics for lifting tasks at work, but her husband noted she was not particularly successful at this. (R. 284) She evidenced no focal motor deficits and sensation of her lower extremities was intact and symmetrical bilaterally. Mark K. Palit, M.D. advised Henrichs to continue with her current medications and also continue working, and return to the doctor as needed. (*Id.*)

Despite numerous doctor visits over the next two years, Henrichs did not complain further about back pain. She complained of intermittent pain in her left flank, left upper chest, shoulder, and arm, and doctors thought her pain was musculoskeletal in nature and likely related to stress. (*See* R. 223-28, 233-41, 243-44; *see also* R. 216, 218, 220) Testing for any type of cardiac problem was negative, and doctors opined her chest pain probably was costochondral in nature. (*See* R. 223-28) Doctors' findings were similar in February and March of 2000, when Henrichs continued to complain of intermittent chest pain, mid-back pain, and right flank pain. (*See* 209, 210, 212-13) In October 2000, Henrichs complained of pain in the right side of her neck, radiating up into her head and distally into her right shoulder. X-rays of her cervical spine showed degenerative disc changes throughout the cervical spine, and Henrichs exhibited some restriction of flexion and extension motion on lateral flexion. (R. 156-57) She told doctors her headache might be secondary to severe stress she had experienced in the preceding few weeks. (R. 190-91)

At one point in March 2000, Henrichs was advised to see a chiropractor for adjustments to help her back pain (R. 209), and in an opinion letter dated March 8, 2001, Cindy Pischke, D.C. indicated she had been seeing Henrichs since 1999. (R. 331) However, there are no other records of chiropractic treatment in the record. On April 13, 2001, Henrichs told Dr. Palit that chiropractic treatment seemed to be more effective than

physical therapy for her neck pain, and she declined a steroidal injection. (R. 388-89) On May 22, 2001, Kevin L. Schminke, M.D. assessed Henrichs with, among other things, osteoarthritis, particularly of the cervical spine. (R. 359)

b. Shortness of breath and irregular heartbeat

Henrichs complained of shortness of breath and an irregular heartbeat in September 1994. A cardiac stress test was normal. (R. 320-21) In early March 1998, Henrichs began complaining of shortness of breath regularly. On March 3, 1998, she reported increased shortness of breath on exertion. Dr. Schminke was unable to find a cause for the condition, but opined it likely was not due to congestive heart failure. He ordered a chest X-ray to rule out heart failure or other pulmonary processes, and the X-ray showed no acute chest disease. (R. 242, 243-44, 246) Henrichs again complained of shortness of breath on March 18, 1998. Dr. Schminke opined the condition was due to stress and/or depression, noting Henrichs's mother, son, and some friends all had died recently. (R. 239-41)

Henrichs returned to the doctor complaining of shortness of breath accompanied by chest pain on January 21, 1999. She reported she had been shoveling snow when she experienced sternal pain radiating up the left side of her neck and down into her left arm. She stated she was short of breath both with activity and occasionally when she was at rest, and she felt her heartbeat was irregular intermittently. She denied any dizziness. An EKG and chest X-ray were normal, and indicated her shortness of breath and rapid heartbeat were not associated with arrhythmia or tachycardia. (R. 229-38)

She continued to complain of shortness of breath on February 23, 1999, and the doctor noted the condition was still of uncertain etiology. (R. 223-28) The condition persisted, and on March 24, 1999, she also complained of some intermittent, sharp,

pleuritic type chest pains. She reported coughing and clearing her throat frequently. She noted Ibuprofen provided good relief, but seemed to be causing palpitations. Dr. Schminke again found no clear cause for her shortness of breath. He scheduled a treadmill exam to rule out coronary disease, and an echocardiogram to rule out pulmonary hypertension. Both studies were normal, and, in fact, Henrichs's exercise stress test results were slightly better than a similar test in 1994. (R. 218-21)

Henrichs next reported shortness of breath on August 22, 2000. Dr. Schminke indicated this could be an element of bronchospasm, noting Henrichs also had a cough and reported generally feeling miserable. (R. 203-06) On September 20, 2000, she reported shortness of breath on any kind of activity, and a racing heartbeat at times. X-rays and testing did not reveal any acute problems, and doctors noted her distress could indicate mild obstructive disease. (R. 193-97) On October 9, 2000, she reported her rapid heartbeat was occurring more frequently and lasting longer. (R. 190-91) She underwent a Holter monitor study where she was monitored for twenty-two hours and ten minutes. During the test, she exhibited "several episodes of palpitations, chest pain and shortness of breath, none of which were associated with any abnormalities," and the test otherwise was normal. (R. 154-55)

c. Sinus and bronchial problems

In addition to complaints of shortness of breath, Henrichs has a history of bronchial asthma, chronic sinusitis, and a recurrent cough since at least January 1996, and she underwent sinus surgery on May 2, 1996. (R. 141-44) She continued to have sinusitis and bronchial problems, and was treated for symptoms related to these conditions on August 1, 1996 (R. 311); October 30, 1996 (*id.*); January 23, 1997 (R. 308); April 22, 1997 (R. 303); May 23, 1997 (R. 302); June 12, 1997 (R. 301); July 17, 1997 (*id.*);

November 27, 1997 (R. 300); January 6, 1998 (R. 299); March 18, 1998 (R. 239-41); July 7 1998 (R. 298); September 16, 1998 (R. 298); December 21, 1998 (R. 296, 297); November 1, 1999 (R. 295); June 5, 2000 (R. 208); and August 22, 2000 (R. 203-06). On all of these occasions, Henrichs was treated conservatively with antibiotics and medications for asthma and allergies.

d. Arthritis

Henrichs's most significant problem during June 1999 was arthritis in her thumbs. She apparently had carpal tunnel surgery in the past, and was diagnosed with arthritis at one point. The first record evidence concerning her thumbs is a visit to Emile C. Li, M.D. on February 14, 1997, when she complained of pain at the base of her left thumb that would radiate when she bumped her thumb or used it. Ultram and Tylenol provided some relief. An X-ray revealed arthritis in the first metacarpal trapezial joint. Dr. Li prescribed a thumb spica splint and recommended an injection. Henrichs declined the injection at that time, and scheduled a follow-up appointment. (R. 294, 207-08) She returned to see Dr. Li on March 14, 1997, and reported the oral anti-inflammatories and thumb splint were not helping the pain. Dr. Li injected the joint with Marcaine, Lidocaine, and Celestone. (R. 303) At her next visit on April 11, 1997, Henrichs reported the injection had not helped for long, and she was having a "significant amount of grinding pain." (*Id.*) The doctor advised her of surgical options, and scheduled a consultation with Dr. Race "for possible trapezial resection and interposition arthroplasty with flexor carpal radialis tendon, or the 'anchovy' procedure." (*Id.*)

Henrichs saw Dr. Race for evaluation of bilateral thumb pain on November 13, 1997. (R. 281-82) She reported the pain had increased in the previous three weeks. She was experiencing tenderness at the base of her left thumb and some tenderness of the right

thumb. Dr. Race noted she had full range of motion in both wrists and a normal neurologic exam. X-rays of the left thumb showed "severe degenerative change and lateral subluxation of the first metacarpal with respect to the trapezium," and "[n]ear bone-on-bone contact." (R. 282) X-rays of the right thumb showed "some preservation of joint space, early degenerative change," and no bone-on-bone contact. (*Id.*) Dr. Race re-injected both thumbs, noting this was the third injection for the left thumb, and directed her to return for a follow-up exam in six weeks.

Henrichs next saw Dr. Race eight months later, on July 21, 1998. She reported increasing problems since the previous November. Her right thumb now was more painful and causing her more problems than the left thumb. The doctor re-injected the right thumb; directed Henrichs to continue taking Tylenol, Ibuprofen, and Ultram; and told her to return for follow-up in three months. (R. 281) She saw Dr. Race again on May 4, 1999, primarily for problems resulting from a fall on her left knee, but also for follow-up regarding her thumbs. She reported exacerbation of her thumb problems. Dr. Race re-injected both thumbs with Kenalog and Xylocaine, and told Henrichs to return for follow-up in six weeks. (R. 278-79)

Henrichs saw Dr. Race again on December 2, 1999. She reported her left hand now was much worse than her right, and was worsening gradually. She stated relief from the injections lasted about a month. She was taking Vioxx and Ultram. X-rays showed degenerative changes of the carpometacarpal articulation of both thumbs, far worse on the left than the right. Dr. Race injected Xylocaine and Kenalog in the right thumb. He recommended surgery on the left "because the trapezium itself is small and significantly arthritic." (R. 276) He directed Henrichs to continue her normal activities as tolerated until her surgery. (R. 274)

On December 17, 1999, Henrichs underwent left excisional arthroplasty with flexor carpi radialis interposition weave on her left thumb. Surgical pathology showed degenerative arthritis, and her post-operative diagnosis was basilar/triscaphe arthritis, left thumb. (R. 147-48, 214, 275, 290) At her post-operative exam on February 18, 2000, Henrichs was doing well. She reported using a wrist splint when she was working, but not otherwise. Dr. Race directed her to continue her activities as tolerated, use the splint at work, continue taking Vioxx, and return for follow-up in three months. (R. 273)

At her next visit on May 18, 2000, Henrichs reported her left thumb continued to do well and was improving, but the arthritis in her right thumb was worsening gradually and causing her more problems. Vioxx helped the pain somewhat. The doctor injected her right thumb with Kenalog and Xylocaine. (R. 272) Henrichs saw Dr. Race again on September 19, 2000. She reported her right thumb had worsened and she had "progressive pain and discomfort, difficulty with working." (R. 271) She stated she could not use her right hand effectively due to increased swelling and decreased grip strength. (*Id.*) Dr. Race recommended surgery, and Henrichs underwent excisional arthroplasty with flexor carpi radialis interposition weaves, right thumb, on October 13, 2000. (R. 152-53)

At her post-operative exam on October 25, 2000, Henrichs was doing well and taking only Tylenol and Vioxx for pain. She was placed in a short-arm thumb spica cast, and directed to continue taking Tylenol and Vioxx. (R. 270-71, 393) On November 14, 2000, she reported continuing improvement. She was converted to a thumb spica splint, and was told to begin range of motion and strengthening exercises. (R. 270, 393) On December 21, 2000, she continued to exhibit good progress. She was directed to continue her activities as tolerated, and advised to use the thumb spica splint for heavy lifting. (R. 269, 392) She continued to report improvement on March 6, 2001. (R. 390)

e. Vision problems; multiple sclerosis diagnosis

On September 11, 2000, Henrichs was seen for follow-up of some of her medical problems. While at the doctor's office, she reported having cloudy vision in her left eye following a recent episode of herpes zoster in her eyes. (R. 200-02) Henrichs next complained of vision problems on May 22, 2001, when she saw Dr. Schminke for follow-up regarding pain in her ribs and frequent headaches. Henrichs reported she was having double vision at times late in the day, when she became tired. She reported frequently driving with her hand over one eye, explaining she could see better if she closed her right eye and squinted. Dr. Schminke scheduled her for a brain MRI. (R. 359) The MRI revealed "[m]ultiple focal abnormal signal lesions confined to the white matter of both cerebral hemispheres . . . consistent with a demyelinating process such as multiple sclerosis. The distribution and pattern of these lesions would also be consistent with multiple sclerosis." (R. 356) The study was negative for other lesions or abnormalities. (*Id.*)

Dr. Schminke recommended Henrichs have a neurologic evaluation as soon as possible. She was seen by ophthalmologist Gregory A. Olson, M.D. on May 29, 2001, for an evaluation of her vision problems. (R. 374-75) His assessment was, "Nuclear cataract, BVO, motility defect with possible demyelinating disease." (R. 375) The doctor opined as follows: "I don't believe this tiny BVO has any connection with the patient's symptoms. In retrospect, it's certainly possible that starting last Oct. there was the beginning of some neurologic process, but [the] patient indicated things stabilized. Even today straight on, the patient has single vision unless cross-cover testing is done." (*Id.*)

At a follow-up visit on July 24, 2001, Dr. Olson's assessment was "Nuclear cataract, BVO and MS w/secondary strabismus. [Patient] appears stable at this time." (R. 373)

f. Other evidence

In addition to treatment records from Henrichs's treating physicians, the record contains questionnaires completed by Henrichs, evaluations by consulting experts, and opinion letters from Cindy Pischke, D.C. and Dr. Schminke.

Henrichs completed a Personal Pain/Fatigue Questionnaire on August 2, 2000, in which she identified her areas of pain as her left leg and hip, and her right hand. (R. 109) She indicated her right hand hurt all the time. The pain worsened with movement and weather changes, and stopped when she held it completely still. She stated the pain had become "much worse" over the preceding twelve months. (R. 110) She noted Vioxx helped her hand and hip/leg pain, but caused stomach pain; Ultram helped somewhat; and Tylenol helped. She noted she was seeing a chiropractor often and receiving some relief from that treatment. (*Id.*)

Regarding how her pain limited her activities, Henrichs noted, "I cannot work in the salvage yard because it is to[o] painful to use tools and standing is painful." (*Id.*) She indicated she had stopped or restricted the following activities because of her pain: "exercise bike, daily walks, loading & unloading trucks, riding in vihicle [sic] for long drive." (*Id.*) She complained of difficulty dressing herself, and stated she was unable to open certain doors ("car door, house doors") and bottles, peel potatoes, write, button her shirt, or pull up her pants. (R. 111) She noted the pain woke her at night, and she would get up and take Tylenol. (*Id.*) Henrichs described her typical day as follows: "I get up and make my bed, do some dishes, put laundry in washer, watch TV or read, let my dog out for [a]while. I ride into town with my husband, make supper, bath[e] and watch TV." (R. 112)

Henrichs also completed a Supplemental Disability Report on August 2, 2000, in which she indicated she did some household chores, including dusting, sweeping floors,

scrubbing floors twice a month, and grocery shopping once a week; she drove about five times per week; she read and watched TV; and she had a flower garden. (R. 113-14) She stated she could sit for thirty to sixty minutes at a time, but she did not do as much walking and sitting as she used to because it bothered her hip and leg. (*Id.*) She indicated she had become depressed because she had gained weight. (R. 115)

On October 12, 2000, a disability examination was conducted by E. Reveiz, M.D. (R. 247-51) After taking a history from Henrichs and examining her, the doctor diagnosed her with "history of headaches, probably tensional or related with chronic sinusitis"; "history of backache, probably musculo-skeletal in nature"; and "status post excisional arthroplasty left thumb and worsening arthritis of the right thumb which is going to be surgically treated on 10-13-00." (R. 248) Dr. Reveiz opined as follows:

> I don't believe the patient is completely disabled. She is asking [for] disability on grounds of the headaches which she believes is due to spasms or sinuses and backache which is chronic. An extensive work-up has been done and is negative for anything that could go against working at least part-time. I believe she can do the book work in the husband's business, [and] she could answer the phone. She could work at least part-time.

(*Id.*) Dr. Reveiz found Henrichs had the following abilities:

> 1) She is limited in lifting no more than 15 pounds and this should not be a repetitive movement.
> 2) She cannot stand for long periods of time in one position, but she can move about. She can also do walking and if she cannot sit for an 8 hour day, I would say, 4-6 hours would suffice.
> 3) Stooping should be limited as well as climbing and kneeling and crawling.
> 4) No problems with handling objects, seeing, hearing, speaking or traveling.

> 5) I don't see any problems with the work environment in relation to dust, fumes, temperature or common hazards.

(R. 251)

A Physical Residual Functional Capacity ("RFC") Assessment was performed on December 15, 2000, by Jacinto V. de Borja, M.D. (R. 258-66) Dr. de Borja agreed Henrichs has degenerative changes in her spine, but he found her subjective complaints of "severe spasm of the neck and back" to be disproportionate to the medical evidence. He explained that if her complaints were fully credible, the episodes of neck and back spasm "should be frequent enough and last long enough to be significant. Available medical evidence show[s] infrequent visit[s] for the neck problem and physical examination[s] show a supple neck with good range of motion without any neurologic deficit." (R. 266) He found her main problem was the arthritis in her thumbs, which had been treated surgically since that time.

Dr. de Borja concluded that prior to June 30, 1999, Henrichs would have been able to lift/carry twenty pounds occasionally and ten pounds frequently; stand, walk, or sit, with normal breaks, for a total of six hours in an eight-hour workday, for each activity; frequently climb ramps and stairs, balance, stoop, and kneel; and occasionally crouch and crawl. She should never climb ladders, ropes, or scaffolds, and she had a limited ability to reach in all directions, including overhead. She was unlimited in handling (gross manipulation), fingering (fine manipulation), and feeling (skin receptors) abilities, and had no visual, communicative or environmental limitations. (R. 258-65) He further noted that her activities of dusting, sweeping floors, gardening, and scrubbing floors twice a month supported Dr. Reveiz's conclusion that Henrichs could do light work. (R. 266)

On March 8, 2001, Cindy Pischke, D.C. wrote an opinion letter in which she stated she began treating Henrichs in 1999, for pain in her thoracic and cervical spine. Chiro-

practic adjustments provided only short-term relief. Dr. Pischke indicated that since 1999, Henrichs has limited her activities such as lifting, climbing, and riding long distances in the car because those activities aggravated her arthritis. Dr. Pischke recommended Henrichs be limited to lifting only five to ten pounds, and perform no repetitive motions with her hands and wrists. The doctor stated Henrichs was encouraged to walk to assist her in weight loss and to keep her joints mobile. She opined Henrichs's condition would continue to progress over time, with an accompanying regression of her capabilities. She recommended Henrichs limit her activities to prevent premature exacerbation of her symptoms. (R. 331)

A Physical RFC Assessment was performed by Claude H. Koons, M.D. on April 9, 2001. (R. 332-40) He noted Henrichs "continue[d] to have a considerable amount of discomfort," but she nevertheless appeared able to do the following: lift or carry twenty pounds occasionally and ten pounds frequently; stand, walk, or sit, with normal breaks, for six hours in an eight-hour workday (for each activity); and frequently climb ramps and stairs, balance, stoop, kneel, crouch, and crawl. Dr. Koons found her ability to do fingering tasks (fine manipulation) was limited, but she had no other exertional, postural, visual, communicative, or environmental limitations. (*Id.*)

David Christiansen, Ph.D. completed a Psychiatric Review Technique on April 29, 2001. (R. 341-55) He found that although Henrichs had indicated, in August 2000, that her illness caused her to be depressed, the limited evidence of record indicated she did not have a severe mental impairment prior to June 30, 1999. (R. 341)

Dr. Schminke wrote two opinion letters regarding Henrichs's condition. As noted later in this opinion, the ALJ discounted the letter dated October 3, 2001 (R. 397-98), finding it was not relevant to Henrichs's condition in June 1999. Dr. Schminke wrote a second letter dated May 8, 2002. (R. 406-08) He noted his office had treated Henrichs

for a number of conditions since 1993, and he offered the following opinions regarding Henrichs's condition in 1999:

> In 1999, [Henrichs] would have been limited in the amount of time she could stand or walk. Due to her arthritic condition and shortness of breath, she would undoubtedly have difficulty standing more than 1 hour at a time and walking more than 20 minutes. [She] had continual pain and fatigue upon exertion in 1999. Additionally, her chronic low back condition and knee pain in 1999 would have limited her ability to stand and walk. Despite years of prescribed exercise, in 1999 [Henrichs] began complaining that she was unable to walk as far and had to rest during and after walking or riding her bike due to [shortness of breath] and pain. . . .
>
> The patient would also have [had] limitations in lifting, reaching, or sitting for long periods. Due to the intermittent neck, shoulder, and arms pain she was experiencing in 1999, her ability to lift and reach would have been compromised. The severe nature of the bilateral arthritis would also have limited her ability to lift and/or carry more than 10 pounds on a regular basis. . . . [R]epetitive and frequent lifting/carrying would have certainly been limited by her low back condition, despite [her] following prescribed medication and chiropractic therapy.
>
> [The patient's] dexterity and ability to manipulate any type of item on a continual basis would have been hindered by her thumb impairments, assuming 8 hours a day, 5 days a week, etc.
>
> The patient had continual complaints of exacerbation of symptoms due to exertion of activity in 1999. [She] tried to help with her husband[']s salvage business and those activities became increasingly difficult as well as typical household activity. [She] complained of [shortness of breath], easy fatigue, pain in neck, shoulders, and arms, which would be due to the benign arrhythmias and migratory arthritis.

From a medical standpoint, the patient's complaints of pain are credible and consistent with her diagnoses at the time, and her medical history. Her complaints [of] pain in thumbs, neck, shoulder, arms, and back are consistent with her type of arthritis. The complaints of headache and fatigue would also be consistent considering her chronic pain, [shortness of breath] and possibly her later diagnosis of [multiple sclerosis].

After reviewing the progress notes, the patient appears to have had "good days" and "bad days" in 1999. This would also be consistent with her diagnoses. The recurring nature of her condition and symptoms would suggest she would have days in which she would be able to perform activity at a higher level than others. This is also evident in that she would have exacerbation of symptoms for days after performing routine tasks on days that she felt good.

The patient has had multiple steroid injections between 1997 and 1999. These gave short-term relief and her condition later required surgical intervention. She has had a trial of oral steroids, which have been met with only partial success. She did experience a modest improvement in some of her symptoms with the steroids, but after the Prednisone was withdrawn, the symptoms would recur. The patient has a history of gastritis and hypertension, and many medications would exacerbate those symptoms and have to be discontinued.

Given the patient's overall condition in 1999, I do not feel [she] would have been able to perform regular and continuous work 8 hours a day, 5 days a week, 50 weeks a year. As stated above, [she] had attempted to maintain an active lifestyle with work, exercise, and home. She was diligent about trying to lose weight and exercised regularly. This became increasingly difficult for her and although she was able to exercise daily, her symptoms worsened and she became fatigued to the point of exhaustion. Simple tasks at home caused pain and fatigue, and would require [her] to rest frequently. She was able to continue helping her husband with work, but this also exacerbated her symptoms and would

> [require] more rest. The unpredictable nature of her condition in 1999 would undoubtedly prevent her from performing any activity on a consistent and competitive basis.

(R. 406-08)

3. Vocational expert's testimony

The ALJ asked the VE the following hypothetical question:

> With the age of 51 as of the date last insured, female, a twelfth grade education, past relevant work as set forth in [the VE's past relevant work summary], could lift up to ten pounds frequently, 20 pounds occasionally, that's taken from [the RFC Assessment dated 12/15/00, R. 259]. Sitting and standing up to two hours at a time for at least six of an eight-hour day on each of those items. Walking from a mile to two miles. Never working on ladders, ropes, and scaffolds. Only occasional crouching and crawling as per [the RFC Assessment]. Should avoid repetitive hand tools such as wrenches and ratchets due to arthritis in thumbs. Based on this hypothetical, could the Claimant do any [of] her past relevant work?

(R. 62-63)

The VE answered in the negative, and also noted she would not have any transferable skills. Nevertheless, the VE stated there would be some unskilled jobs the hypothetical claimant could perform, including office helper, mail clerk, and inserting machine operator. (R. 63)

The ALJ posed a second hypothetical question to the VE, as follows:

> Assume the age 51 as of the date last insured, female, twelfth grade education, past relevant work as set forth in [the VE's past relevant work summary], lifting up to 20 pounds occasionally, 10 pounds frequently. Sitting and standing up to two hours at a time for a total of six of an eight hour day. Walking from one to two miles. Never climbing ladders, ropes, and

> scaffolds. Only occasional crouching and crawling. Avoid repetitive use of hand tools such as ratchets and wrenches due to problems with arthritis in the thumbs. Due to chronic pain syndrome, depression, or any other reason, the Claimant would miss three or more days of work per month. Would that change any of your answers?

(R. 63-64) The VE responded that the hypothetical claim would be unable to perform the unskilled jobs listed previously, or maintain any other unskilled competitive employment. (R. 64)

4. The ALJ's conclusions

The ALJ found Henrichs was insured from her amended alleged onset date of June 1, 1999, through her date last insured of June 30, 1999, and she did not engage in substantial gainful work activity during that time period. (R. 14, 21) He found that during the relevant period, Henrichs suffered from severe impairments "which have included osteoarthritis of the thumbs; degenerative joint disease with obliteration of the L5-S1 space, disk herniation and stenosis; a torn ACL with lateral meniscus tear; [and] obesity"; however none of her impairments, either singly or in combination, met the requirements of the Listings. (R. 21-22)

The ALJ found Henrichs's subjective allegations concerning the existence, persistence, and intensity of her symptoms and limitations were not fully credible. He discounted Dr. Schminke's letter dated October 3, 2001, finding it was not relevant to the time period prior to Henrichs's date last insured ("DLI").[1] (R. 15) He noted Henrichs's

[1]Dr. Schminke's second letter dated May 8, 2002 (*see* R. 406-08), was considered by the Appeals Council, and is discussed later in this opinion.

treating eye specialist did not find she had any disabling symptoms prior to her DLI. (R. 15)

The ALJ found the evidence indicates Henrichs had degenerative changes in her back that would support her allegations of pain, to some degree. However, he noted "other findings" do not support Henrichs's claim of disabling back pain, as follows:

> On March 3, 1998[, Henrichs] did not complain of back pain. She told the doctor that she usually had been able to walk two miles in less than 20 minutes and that as of that time it took her 20 minutes to walk two miles and then she became really tired. She felt moving around the house and walking down the hall to the doctor's office made her more short of breath than usual [R. 244]. [Henrichs's] ability to walk up to two miles is not consistent with a severe, work precluding degree of pain from her spine. The [ALJ] asked the vocational expert to assume that the hypothetical individual could walk one to two miles. This limitation and others as indicated did not preclude vocational adjustment to a number of jobs the undersigned finds significant on and prior to her date last insured.
>
> On January 21, 1999[, Henrichs] did not make a back related complaint. [She] did complain of sternal pain but [she] had told the doctor that she had been shoveling snow [R. 233]. In late February 1999[, Henrichs] complained of pain in the left upper chest area involving the left shoulder and left arm which did not occur daily. [She] thought it was worse when she would lie down. No back related complaints or diagnoses were made [R. 223].

(R. 16)

The ALJ further noted Henrichs reported exercising regularly; a cardiac stress test in 1999 showed improvement over a prior test in 1994; and her doctor felt her pain complaints were related to chest wall discomfort rather than a cardiac problem. (R. 16) He noted that in October 2000, Henrichs complained of backaches that made it difficult for her to work, but her doctor found "nearly full range of motion of most joints including

the spine"; no muscle weakness, spasms, sensory loss or reflex loss; and Henrichs could walk on her heels and toes. (R. 17) The ALJ observed that although Henrichs saw doctors for elevated blood pressure and headaches, "[t]he absence of persistent complaints made concerning her back is one indication, among others, that indicates any back related complaints were not of a severe, work precluding degree." (R. 16) He therefore found Henrichs did not suffer from a disabling musculoskeletal impairment. (R. 16, 17)

Henrichs saw a doctor with complaints of knee pain in May 1999, and she reported falling on her knee two or three months earlier. An MRI showed a small cyst, and tears to a ligament and the meniscus. The ALJ observed, however, that Henrichs had undergone a cardiac stress test just one to two months before the May 1999 exam that was normal. She did not complain of knee pain during the test and stated she walked five times per week. He found this was consistent with the RFC he had determined for her; *i.e.*, the ability to walk one to two miles, and stand for two hours at a time for no more than six hours in an eight-hour workday. (R. 17)

The ALJ similarly discounted Henrichs's claim that her arthritis precluded her from working in June 1999. He noted the evidence indicates Henrichs had "a fairly good gripping ability" as late as January 21, 1999, when she reported shoveling snow recently, and in any event, the hypothetical posed to the VE accounted for an inability to use hand tools repetitively. He therefore found the arthritis in Henrichs's thumbs did not preclude her from all types of work. (R. 15-16) He further noted that on December 2, 1999, Henrichs told her doctor she was doing "quite a bit of hand work," which worsened her symptoms. (R. 18, citing R. 276) She also reported the injections she had received in May 1999 had helped her symptoms "until about a month ago" (*i.e.*, late October or early November 1999). (*Id.*) The ALJ found these comments supported a finding that Henrichs

would have been able to perform work with her hands in June 1999, as long as she avoided the repetitive use of hand tools. (R. 18)

In discrediting Henrichs's subjective complaints, the ALJ also noted that on a questionnaire she completed in August 2000, Henrichs stated she dusted, swept floors, scrubbed floors twice a month, made one meal a day, drove several times per week, did grocery shopping, and had a flower garden. She stated her husband did the vacuuming, and she reported her hands hurt when she dressed or bathed. (R. 18) The ALJ noted Henrichs's earnings history added "slightly to the credibility of her allegations, showing an individual who has sought to work when able," but based on inconsistencies he identified in the record, the ALJ found Henrichs had the following RFC in June 1999: she could lift twenty pounds occasionally and ten pounds frequently, with no overhead lifting; sit or stand for two hours at a time for a total of six hours in an eight-hour workday; walk one to two miles at a time; and occasionally crouch and crawl. She should avoid climbing ladders, ropes and scaffolds, and avoid the repetitive use of hand tools such as a wrench and ratchet. (R. 20, 22)

The ALJ found Henrichs was unable to perform her past relevant work and she had no transferable work skills, but based on his RFC, she would have been able to perform other occupations of an unskilled nature including office helper, mail clerk, and machine operator. (R. 21, 22) He therefore found Henrichs was not disabled through her DLI of June 30, 1999. (R. 21, 22)

5. The Appeals Council's decision

The Appeals Council considered the updated opinion letter from Henrichs's treating physician, Dr. Schminke, in which he opined Henrichs was disabled in June 1999. The Appeals Council also considered the arguments of counsel, and "the final regulations,

effective February 19, 2002, implementing the new listings for musculoskeletal (and related) impairments." (R. 6) The Appeals Council found the additional evidence did not provide a basis for changing the ALJ's decision. Specifically, the Appeals Council found "Dr. Schminke's opinion regarding [Henrichs's] ability to work in his updated medical statement dated May 8, 2002[,] is not supported by the medical evidence of record considered by the Administrative Law Judge." (R. 6-7)

III. DISABILITY DETERMINATIONS, THE BURDEN OF PROOF, AND THE SUBSTANTIAL EVIDENCE STANDARD

A. Disability Determinations and the Burden of Proof

Section 423(d) of the Social Security Act defines a disability as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." 42 U.S.C. § 423(d)(1)(A); 20 C.F.R. § 404.1505. A claimant has a disability when the claimant is "not only unable to do his previous work but cannot, considering his age, education and work experience, engage in any other kind of substantial gainful work which exists . . . in significant numbers either in the region where such individual lives or in several regions of the country." 42 U.S.C. § 432(d)(2)(A).

To determine whether a claimant has a disability within the meaning of the Social Security Act, the Commissioner follows a five-step sequential evaluation process outlined in the regulations. 20 C.F.R. §§ 404.1520 & 416.920; *Dixon v. Barnhart*, ___ F.3d ___, 2003 WL 22990119 at *2 (8th Cir. Dec. 22, 2003); *Kelley v. Callahan*, 133 F.3d 583, 587-88 (8th Cir. 1998) (citing *Ingram v. Chater*, 107 F.3d 598, 600 (8th Cir. 1997)). First, the Commissioner will consider a claimant's work activity. If the claimant is

engaged in substantial gainful activity, then the claimant is not disabled. 20 C.F.R. § 404.1520(4)(i).

Second, if the claimant is not engaged in substantial gainful activity, the Commissioner looks to see "whether the claimant has a severe impairment that significantly limits the claimant's physical or mental ability to perform basic work activities." *Dixon*, 2003 WL 22990119, at *2. The United States Supreme Court has explained:

> The ability to do basic work activities is defined as "the abilities and aptitudes necessary to do most jobs." . . . Such abilities and aptitudes include "[p]hysical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling"; "[c]apacities for seeing, hearing, and speaking"; "[u]nderstanding, carrying out and remembering simple instructions"; "[u]se of judgment"; "[r]esponding appropriately to supervision, co-workers, and usual work situations"; and "[d]ealing with changes in a routine work setting."

Bowen v. Yuckert, 482 U.S. 137, 140-42, 107 S. Ct. 2287, 2291, 96 L. Ed. 2d 119 (1987) (citing 20 C.F.R. §§ 404.1521(b), 416.921(b)); *accord Lewis v. Barnhart*, ___ F.3d ___, 2003 WL 23025545, at *2 (8th Cir. Dec. 30, 2003) (citing *Bowen*, *inter alia*).

Third, if the claimant has a severe impairment, then the Commissioner will consider the medical severity of the impairment. If the impairment meets or equals one of the presumptively disabling impairments listed in the regulations, then the claimant is considered disabled, regardless of age, education, or work experience. 20 C.F.R. § 404.1520; *Kelley*, 133 F.3d at 588.

Fourth, if the claimant's impairment is severe, but it does not meet or equal one of the presumptively disabling impairments, then the Commissioner will assess the claimant's residual functional capacity ("RFC") to determine the claimant's "ability to meet the physical, mental, sensory, and other requirements" of the claimant's past relevant work.

20 C.F.R. §§ 404.1520(4)(iv); 404.1545(4); *see Dixon*, *supra*. The claimant is responsible for providing evidence the Commissioner will use to make a finding as to the claimant's RFC, but the Commissioner is responsible for developing the claimant's "complete medical history, including arranging for a consultative examination(s) if necessary, and making every reasonable effort to help [the claimant] get medical reports from [the claimant's] own medical sources." 20 C.F.R. § 404.1545(3). The Commissioner also will consider certain non-medical evidence and other evidence listed in the regulations. *See id*. If a claimant retains the RFC to perform past relevant work, then the claimant is not disabled. 20 C.F.R. § 404.1520(4)(iv).

Fifth, if the claimant's RFC as determined in step four will not allow the claimant to perform past relevant work, then the burden shifts to the Commissioner "to prove that there is other work that [the claimant] can do, given [the claimant's] RFC [as determined at step four], age, education, and work experience." Clarification of Rules Involving Residual Functional Capacity Assessments, etc., 68 Fed. Reg. 51,153, 51,155 (Aug. 26, 2003). The Commissioner must prove not only that the claimant's RFC will allow the claimant to make an adjustment to other work, but also that the other work exists in significant numbers in the national economy. *Id.*; 20 C.F.R. § 404.1520(4)(v); *Dixon, supra*; *Pearsall v. Massanari*, 274 F.3d 1211, 1217 (8th Cir. 2001) ("[I]f the claimant cannot perform the past work, the burden then shifts to the Commissioner to prove that there are other jobs in the national economy that the claimant can perform.") (citing *Cox v. Apfel*, 160 F.3d 1203, 1206 (8th Cir. 1998)); *Nevland v. Apfel*, 204 F.3d 853, 857 (8th Cir. 2000). If the claimant can make an adjustment to other work that exists in significant numbers in the national economy, then the Commissioner will find the claimant is not disabled. If the claimant cannot make an adjustment to other work, then the Commissioner will find the claimant is disabled. 20 C.F.R. § 404.1520(r)(v).

B. The Substantial Evidence Standard

Governing precedent in the Eighth Circuit requires this court to affirm the ALJ's findings if they are supported by substantial evidence in the record as a whole. *Krogmeier v. Barnhart*, 294 F.3d 1019, 1022 (8th Cir. 2002) (citing *Prosch v. Apfel*, 201 F.3d 1010, 1012 (8th Cir. 2000)); *Weiler, supra,* 179 F.3d at 1109 (citing *Pierce v. Apfel*, 173 F.3d 704, 706 (8th Cir. 1999)); *Kelley, supra,* 133 F.3d at 587 (citing *Matthews v. Bowen*, 879 F.2d 422, 423-24 (8th Cir. 1989)); 42 U.S.C. § 405(g) ("The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive. . . ."). Under this standard, "[s]ubstantial evidence is less than a preponderance but is enough that a reasonable mind would find it adequate to support the Commissioner's conclusion." *Krogmeier, id.*; *Weiler, id.*; *accord Gowell v. Apfel*, 242 F.3d 793, 796 (8th Cir. 2001) (citing *Craig v. Apfel*, 212 F.3d 433, 436 (8th Cir. 2000)); *Hutton v. Apfel*, 175 F.3d 651, 654 (8th Cir. 1999); *Woolf v. Shalala*, 3 F.3d 1210, 1213 (8th Cir. 1993).

Moreover, substantial evidence "on the record as a whole" requires consideration of the record in its entirety, taking into account both "evidence that detracts from the Commissioner's decision as well as evidence that supports it." *Krogmeier,* 294 F.3d at 1022 (citing *Craig*, 212 F.3d at 436); *Willcuts v. Apfel*, 143 F.3d 1134, 1136 (8th Cir. 1998) (quoting *Universal Camera Corp. v. N.L.R.B.*, 340 U.S. 474, 488, 71 S. Ct. 456, 464, 95 L. Ed. 456 (1951)); *Gowell*, 242 F.3d at 796*; Hutton*, 175 F.3d at 654 (citing *Woolf*, 3 F.3d at 1213); *Kelley*, 133 F.3d at 587 (citing *Cline v. Sullivan*, 939 F.2d 560, 564 (8th Cir. 1991)). The court must "search the record for evidence contradicting the [Commissioner's] decision and give that evidence appropriate weight when determining whether the overall evidence in support is substantial." *Baldwin v. Barnhart*, 349 F.3d 549, 555 (8th Cir. 2003) (also citing *Cline*, *supra*).

In evaluating the evidence in an appeal of a denial of benefits, the court must apply a balancing test to assess any contradictory evidence. *Sobania v. Secretary of Health & Human Serv.*, 879 F.2d 441, 444 (8th Cir. 1989) (citing *Steadman v. S.E.C.*, 450 U.S. 91, 99, 101 S. Ct. 999, 1006, 67 L. Ed. 2d 69 (1981)). The court, however, does not "reweigh the evidence presented to the ALJ," *Baldwin*, 349 F.3d at 555 (citing *Bates v. Chater*, 54 F.3d 529, 532 (8th Cir. 1995)), or "review the factual record *de novo*." *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996) (citing *Naber v. Shalala*, 22 F.3d 186, 188 (8th Cir. 1994)). Instead, if, after reviewing the evidence, the court finds it "possible to draw two inconsistent positions from the evidence and one of those positions represents the agency's findings, [the court] must affirm the [Commissioner's] decision." *Id.* (quoting *Robinson v. Sullivan*, 956 F.2d 836, 838 (8th Cir. 1992), and citing *Cruse v. Bowen*, 867 F.2d 1183, 1184 (8th Cir. 1989)); *accord Baldwin*, 349 F.3d at 555. This is true even in cases where the court "might have weighed the evidence differently." *Culbertson v. Shalala*, 30 F.3d 934, 939 (8th Cir. 1994) (citing *Browning v. Sullivan*, 958 F.2d 817, 822 (8th Cir. 1992)); *accord Krogmeier,* 294 F.3d at 1022 (citing *Woolf*, 3 F.3d at 1213). The court may not reverse the Commissioner's decision "merely because substantial evidence would have supported an opposite decision." *Baldwin*, 349 F.3d at 555 (citing *Grebenick v. Chater*, 121 F.3d 1193, 1198 (8th Cir. 1997); *see Pearsall,* 274 F.3d at 1217; *Gowell*; 242 F.3d at 796; *Spradling v. Chater*, 126 F.3d 1072, 1074 (8th Cir. 1997).

On the issue of an ALJ's determination that a claimant's subjective complaints lack credibility, the Sixth and Seventh Circuits have held an ALJ's credibility determinations are entitled to considerable weight. *See, e.g., Young v. Secretary of H.H.S.,* 957 F.2d 386, 392 (7th Cir. 1992) (citing *Cheshier v. Bowen,* 831 F.2d 687, 690 (7th Cir. 1987)); *Gooch v. Secretary of H.H.S.,* 833 F.2d 589, 592 (6th Cir. 1987), *cert. denied*, 484 U.S. 1075, 108 S. Ct. 1050, 98 L. Ed. 2d. 1012 (1988); *Hardaway v. Secretary of H.H.S.,* 823

F.2d 922, 928 (6th Cir. 1987). Nonetheless, in the Eighth Circuit, an ALJ may not discredit a claimant's subjective allegations of pain, discomfort or other disabling limitations simply because there is a lack of objective evidence; instead, the ALJ may only discredit subjective complaints if they are inconsistent with the record as a whole. *See Hinchey v. Shalala,* 29 F.3d 428, 432 (8th Cir. 1994); *see also Bishop v. Sullivan,* 900 F.2d 1259, 1262 (8th Cir. 1990) (citing *Polaski v. Heckler,* 739 F.2d 1320, 1322 (8th Cir. 1984)). As the court explained in *Polaski v. Heckler:*

> The adjudicator must give full consideration to all of the evidence presented relating to subjective complaints, including the claimant's prior work record, and observations by third parties and treating and examining physicians relating to such matters as:
>
> 1) the claimant's daily activities;
> 2) the duration, frequency and intensity of the pain;
> 3) precipitating and aggravating factors;
> 4) dosage, effectiveness and side effects of medication;
> 5) functional restrictions.

Polaski, 739 F.2d 1320, 1322 (8th Cir. 1984). *Accord Ramirez v. Barnhart*, 292 F.3d 576, 580-81 (8th Cir. 2002).

IV. ANALYSIS

A. Substitution of ALJ's Opinions for Those of Treating Physicians

Henrichs asserts the ALJ erred in several respects in finding her not to be disabled. She begins by arguing the ALJ usurped the opinions of her treating physicians "at least three times during the course of [his] decision," and substituted "his own speculation" in their place. (Doc. No. 13, pp. 5-6) First, she argues the ALJ's conclusion that she "had

a fairly good gripping ability" based on her report of shoveling snow is unwarranted, claiming "the ALJ should have noted that this was a most unusual circumstance and occurred on one occasion when [Henrichs's] husband was in the hospital." (*Id.*, p. 6, citing R. 233) The cited record entry contains nothing to inform the ALJ that Henrichs's report of shoveling snow was an isolated incident when her husband was in the hospital, and the court has found no other evidence in the record from which the ALJ could have learned this information. Nevertheless, the court agrees it was improper for the ALJ to conclude Henrichs's "ability to shovel snow indicates that she had a fairly good gripping ability." (R. 15) The ALJ pointed to no other evidence to support his conclusion, and the court has found none. In fact, substantial evidence in the record supports the opposite conclusion. The evidence indicates Henrichs's hand pain significantly restricted her ability to use her hands in June 1999, and continued to do so until October 2000.

Second, she argues the evidence does not support the ALJ's conclusion that her ability to walk up to two miles was inconsistent with severe back pain. (Doc. No. 13, p. 6, citing R. 16). The court agrees. Dr. Pischke noted Henrichs was encouraged to walk regularly to help her maintain her weight and keep her joints mobile. (R. 331) Her ability to walk one to two miles does not contradict her claims of severe back pain. On the other hand, the evidence indicates that prior to June 30, 1999, Henrichs was not experiencing back pain so severe that it would have prevented her from performing basic work activities for any significant period of time. She undoubtedly had some degree of back pain, but based on her contemporaneous reports to her doctors, she continued to function normally in her routine activities, and her back pain was not disabling.

Third, Henrichs notes the ALJ's assertion that cortisone injections resolved her hand problems is incorrect. (Doc. No. 13, p. 7, citing R. 18) Again, the court agrees.

Henrichs reported the injections gave her only short-term relief, and both of her thumbs ultimately required surgery.

B. Weight of Evidence, Credibility Determination, RFC Assessment, and Accuracy of Hypothetical Questions

Henrichs's remaining arguments are intertwined to such an extent that they can be considered together. She argues the ALJ improperly weighed the opinions of the medical experts, resulting in an RFC assessment that did not accurately reflect Henrichs's limitations. She further argues the ALJ improperly discounted her credibility. She claims that as a result of these improper conclusions, the ALJ failed to include all of her impairments and limitations in the hypothetical questions posed to the VE.

Henrichs argues the ALJ erred in giving "great weight" to the opinions of the medical consultants, Dr. Koons and Dr. de Borja, both of whom conducted only a paper review of Henrichs's records, and neither of whom examined her. She claims the ALJ improperly discounted the RFC determination from Dr. Reveiz, who did examine her, and further erred in failing to obtain an RFC assessment from her treating physicians. (Doc. No. 13, pp. 7-9[2]) Henrichs argues further that the Appeals Council compounded the error by ignoring Dr. Schminke's updated opinion letter. (*Id.*, p. 9)

The court finds the ALJ did not err in discounting Dr. Schminke's initial opinion letter. There was nothing in the letter to indicate Dr. Schminke was providing information about Henrichs's condition during June 1999. The ALJ noted that although the letter might accurately portray Henrichs's current inability to function, it was not relevant to the time period in question. (*See* R. 15) Similarly, the ALJ did not err in giving greater weight

[2]Henrichs's reliance on Dr. Reveiz's opinion is curious, given the doctor's opinion that she could work at least part-time. (*See* R. 248)

to the opinions of Dr. Koons and Dr. de Borja than to Dr. Reveiz's opinion. None of these three doctors treated Henrichs. Dr. Reveiz examined her one time, seventeen months after Henrichs's DLI, for purposes of a disability evaluation. Even at that time, Dr. Reveiz found Henrichs was capable of at least part-time work.

However, the court agrees with Henrichs that the ALJ erred in failing to obtain an RFC assessment from Henrichs's treating physicians. It is the ALJ's duty to develop the record fully and fairly, even in cases where the claimant is represented by counsel. *Battles v. Shalala*, 36 F.3d 43, 44 (8th Cir. 1994) (citing *Boyd v. Sullivan*, 960 F.2d 733, 736 (8th Cir. 1992); *Warner v. Heckler*, 722 F.2d 428, 431 (8th Cir. 1983)); *Dozier v. Heckler*, 754 F.2d 274, 276 (8th Cir. 1985). The relevant question is whether the medical evidence available to the ALJ provides a sufficient basis for a decision in favor of the Commissioner. *Scott v. Apfel*, 89 F. Supp. 2d 1066, 1076 (N.D. Iowa 2000) (Bennett, C.J.) When the evidence is lacking, but reasonably available, it is the ALJ's duty to obtain the evidence. *Battles, supra; Scott, supra*. *But see Onstad v. Shalala*, 999 F.2d 1232, 1234 (8th Cir. 1993) (it is of some relevance that the claimant's attorney did not obtain the items being complained about) (citing *Phelan v. Bowen*, 846 F.2d 478, 481 (8th Cir. 1988).

In the present case, the ALJ had before him a detailed opinion letter written by Henrichs's treating physician, Dr. Schminke, and records indicating the doctor had treated Henrichs for several years, including the time period at issue. The ALJ failed to ask Dr. Schminke for an assessment of Henrichs's RFC as of June 1999, or even to pose an appropriate interrogatory to determine the time period during which the doctor's opinion was relevant. In failing to obtain further information from Henrichs's treating physicians, the ALJ abdicated his special duty of inquiry "to scrupulously and conscientiously explore for all relevant facts." *Heckler v. Campbell*, 461 U.S. 458, 471 & n.1, 103 S. Ct. 1952, 1959 & n.1, 76 L. Ed. 2d 66 (1983) (Brennan, J., concurring).

Equally disturbing is the Appeals Council's rejection of Dr. Schminke's updated opinion letter with nothing more than a statement that the doctor's opinion was "not supported by the medical evidence of record considered by the [ALJ]." (R. 6-7) The court lacks jurisdiction to review the Appeals Council's decision to deny a request for review. *Piepgras v. Chater*, 76 F.3d 233, 238 (8th Cir. 1996); *Browning v. Sullivan*, 958 F.2d 817, 822 (8th Cir. 1992). However, the court has jurisdiction to consider "whether the Appeals Council has complied with the procedural requirements of the regulations." *Browning*, 958 F.2d at 823. The Regulations provide the Appeals Council must "follow the same rules for considering opinion evidence as administrative law judges follow." 20 C.F.R. § 404.1527(f)(3). This court agrees with those courts that have held when the Appeals Council considers new evidence that was not available to the ALJ, the Appeals Council must justify its decision to reject that evidence with more than a *pro forma* statement that the evidence does not warrant changing the ALJ's decision. *See*, *e.g.*, *Hawker v. Barnhart*, 235 F. Supp. 2d 445, 452 (D. Md. 2002) ("[I]f the Appeals Council ostensibly considers evidence submitted post-ALJ hearing and that evidence is part of the administrative record, . . . then a duty of explanation is necessary. . . ."[3]). The Appeals Council therefore should have justified its decision to reject Dr. Schminke's updated opinion pursuant to the factors listed in 20 C.F.R. § 404.1527(d), such as the length and extent of the treatment relationship between Henrichs and the doctor, the frequency of examination, the doctor's specialization in the area of treatment, and the extent to which

[3]The *Hawker* court discussed the ambiguous status of a memorandum "temporarily" suspending the Appeals Council's duty of explanation due to a backlog of cases, but the court noted "the HALLEX manual provides further support that the Appeals council should, and can, provide explanation for its handling of additional evidence it deems to consider," and in any event, neither the suspension memorandum nor the HALLEX manual is binding on the court. *Id.*, 235 F. Supp. 2d. at 452.

the doctor's opinion is supported or contradicted by other evidence in the record. The court finds the Appeals Council's rejection of this evidence without explanation was error.

Although Dr. Schminke's opinion is based largely on Henrichs's subjective complaints to him, the record indicates Henrichs consistently voiced complaints of pain and limitations throughout her lengthy treatment relationship with the doctor, and her complaints continually increased as time went on. Further, Dr. Schminke noted Henrichs's pain complaints were "credible and consistent with her diagnoses at the time, and her medical history." (R. 407) He noted she would have had "good days," when she could perform activity at a higher level than her "bad days." (*Id.*) In addition, Henrichs sought medical treatment for her various complaints frequently, and by her doctors' reports, she was diligent in following doctors' orders, taking medications as directed, and exercising.

A problem exists with respect to Dr. Schminke's revised opinion. He refers repeatedly to Henrichs's condition "in 1999." The relevant period for purposes of this case is a very limited part of 1999; *i.e.*, June 1-30, 1999. It is impossible to tell whether the doctor directed his opinion to that particular period, or to 1999 as a whole. If his opinion applies to the specific time period at issue, and his opinion is given proper weight considering his treatment relationship with Henrichs, then the ALJ's RFC assessment, as reflected in the hypothetical questions posed to the VE, did not accurately encompass all of Henrichs's limitations for several reasons. As discussed below, even without Dr. Schminke's revised opinion, the court finds the ALJ's RFC assessment was inaccurate.

First, Dr. Schminke's opinion substantiates Henrichs's complaints of limitation relating to her hands. Even without his revised opinion, however, the record contains substantial evidence to indicate Henrichs's hand pain significantly limited her activities in

June 1999, the impairment had continued for a consecutive twelve-month period prior to that time, and the impairment continued until October 2000.

Second, Dr. Schminke opined Henrichs would have been able to stand for up to one hour at a time. The hypothetical assumed she could stand for up to two hours at a time for a total of at least six hours in an eight-hour day. Thus, based on the doctor's opinion, the hypothetical overstated Henrichs's ability to stand.

Dr. Schminke stated the arthritis in Henrichs's thumbs would have limited her manual dexterity and ability "to manipulate any type of item on a continual basis." (R. 407) The hypothetical indicated she should avoid the use of repetitive hand tools such as wrenches and ratchets. Avoiding repetitive hand tools would be included within her limitations, but it does not go far enough in accurately stating Henrichs's limitations caused by her arthritis.

Therefore, although the hypothetical questions were consistent with Dr. Schminke's opinion regarding Henrichs's ability to walk[4] and her lifting limitations,[5] the hypotheticals did not accurately reflect her limitations due to the arthritis in her hands, or her ability to stand for only one hour at a time. Even if Dr. Schminke is unable to confine his opinion to June 1999, the court still finds the hypothetical questions did not accurately reflect the limitations caused by the arthritis in Henrichs's thumbs.

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[4]Dr. Schminke opined Henrichs would have been able to walk for up to twenty minutes. Henrichs stated it took her about twenty minutes to walk two miles. Therefore, the hypothetical, which assumed she could walk from one to two miles, accurately reflected her walking limitations.

[5]Dr. Schminke opined Henrichs could lift up to ten pounds on a regular basis. He did not provide an opinion about how much she could lift on an occasional basis. The hypothetical assumed she could lift up to ten pounds frequently, and twenty pounds occasionally. The court finds the hypothetical was consistent with Dr. Schminke's opinion regarding Henrichs's lifting abilities.

Because the hypothetical questions to the VE did not encompass all of Henrichs's relevant impairments, and the degree to which they affected her ability to work, the VE's testimony cannot constitute substantial evidence upon which the ALJ could rely in finding Henrichs was not disabled during June 1999. *See Hunt v. Massanari*, 250 F.3d 622, 626 (8th Cir. 2001) (citing *Hinchey v. Shalala*, 29 F.3d 428, 432 (8th Cir. 1994)).

The Commissioner has failed to meet her burden to show Henrichs was capable, in June 1999, of performing jobs that existed in substantial numbers in the national economy. Such a showing would have required vocational expert testimony based upon an accurate hypothetical question encompassing all of Henrichs's limitations. An accurate hypothetical question would have considered the fact that Henrichs was unable to use her hands for any type of find manipulation or repetitive movements. In addition, if Dr. Schminke can confine his opinion to June 1999, and giving his opinion the weight it deserves based on the evidence, Henrichs could only stand for up to one hour at a time; she experienced shortness of breath upon exertion; she could walk for up to twenty minutes at a time; and she could lift up to ten pounds frequently and twenty pounds occasionally with no overhead lifting. With or without Dr. Schminke's revised opinion, with Henrichs's hand limitations, she would have been unable to perform any of the three jobs listed by the VE. As Henrichs notes in her brief, all three of those occupations (office helper, mail clerk, and inserting machine operator) require reaching, handling, and fingering in excess of Henrichs's capabilities in June 1999.

Because the Commissioner failed to meet her burden at step five of the sequential evaluation process, her denial of benefits to Henrichs was improper. However, the court is unable to say unequivocally, from the current record, that Henrichs was disabled as of June 30, 1999. The court therefore finds it is appropriate to remand this case to the Commissioner for further proceedings, including consideration of Dr. Schminke's updated

opinion, obtaining further clarification from the doctor of the time period represented by that opinion, and obtaining further testimony by a vocational expert that takes into consideration all of Henrichs's impairments and limitations. *See Ingram v. Barnhart*, 303 F.3d 890, 895 (8th Cir. 2002) ("When the Commissioner's decision to deny benefits is improper, we ordinarily will remand for further proceedings out of an abundance of deference to the agency's authority to make benefits determinations," except where record overwhelmingly supports a finding of disability.) (citing *Buckner v. Apfel*, 213 F.3d 1006, 1011 (8th Cir. 2000)).

V. CONCLUSION

For the reasons discussed above, the Commissioner's decision is **reversed**, and this case is **remanded** to the Commissioner for further proceedings consistent with this opinion.[6]

IT IS SO ORDERED.

DATED this 3rd day of February, 2004.

PAUL A. ZOSS
MAGISTRATE JUDGE
UNITED STATES DISTRICT COURT

[6]NOTE: The plaintiff's counsel must comply with the requirements of Local Rule 54.2(b) in connection with any application for attorney fees.